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## The Oregon Multidimensional Treatment Foster Care Model: Features, Outcomes, and Progress in Dissemination

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*The practice of placing children and adolescents with severe antisocial behavior and delinquency in residential and group home settings is commonplace in most communities in the United States, yet little research exists on the short- or long-term effectiveness of such placements. Furthermore, recent evidence suggests that there are potentially damaging effects from placement in congregate care settings that relate to negative influences that problem youth who are placed together tend to have on each other. The Oregon Multidimensional Treatment Foster Care (MTFC) model was developed as an alternative to group and residential care for youth with delinquency and severe emotional and behavioral problems. The central features of the Oregon MTFC model are described, evidence on the efficacy of the model is reviewed, and practical aspects relating to dissemination are discussed along with conditions that act to facilitate or create barriers to implementation.*

THE OREGON Multidimensional Treatment Foster Care (MTFC) model was originally developed for adolescents who were committed to and then diverted from the Oregon State Training Schools for severe and chronic problems with delinquency. Subsequently, the model has been adapted for and tested with two other groups: children and adolescents who are being stepped down from placement in the state hospital, and youngsters in state-supported foster care. Randomized trials have been conducted with each of these three populations. Other adaptations of MTFC are under way but have not yet been subjected to rigorous empirical evaluation. These include MTFC for developmentally delayed youth who have problems with inappropriate sexual behavior and multiple placement failures, and youth referred from managed

care mental health systems who are in need of out-of-home placement. Three additional randomized trials are currently under way. The first is for girls referred from juvenile justice who have multiple criminal offenses and mental health problems. The second is an adaptation of MTFC for preschoolers in state-supported foster care that includes the assessment of psychophysiological functioning. The third is an effectiveness study of an application of MTFC "Lite" in a large urban child welfare foster care system. In that study, the process of disseminating the intervention is also being examined. This paper will focus on the populations and findings from the three completed randomized trials (i.e., with youth from juvenile justice, mental health, and "regular" foster care).

### Central Features of the Oregon Treatment Foster Care Model

The major aim of MTFC is twofold: to create supports and opportunities for children and adolescents so they can have a successful community living experience and to

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prepare their parents, relatives, or other aftercare placement resources to use skills and methods that will allow youngsters to maintain the gains they made while in MTFC once they return home. In MTFC, interventions are implemented using multiple methods (e.g., family and individual therapy, skill training, academic supports) in a number of key settings. Typically, MTFC placements are short-term (from 6 to 9 months). From the beginning of placement, work with the youth's parents is emphasized to prepare the youth and the adults for post-MTFC life. Four key elements are targeted in MTFC and in aftercare.

1. Providing the youth with a consistent reinforcing environment where he or she is mentored and encouraged.
2. Providing a clear structure and limits with well-specified consequences that can be delivered in a teaching-oriented way.
3. Providing close supervision of the youth's whereabouts.
4. Avoiding associations between youth in MTFC and peers with problems and helping MTFC youth develop skills for having relationships with positive peers.

Several program practices are used to accomplish these aims. We pay close attention, on a daily basis, to the youth's progress and problems both in the MTFC home and in school. Daily data are collected so that we can carefully track progress and problems and monitor implementation of the model in the MTFC home. In addition, we keep track of foster parent stress levels on a daily basis and continually monitor key variables that relate to more long-term case outcomes. Daily data are collected from MTFC parents via a brief telephone interview (i.e., the Parent Daily Report Checklist; PDR; Chamberlain & Reid, 1987). Program supervisors, who are responsible for supervising all aspects of the treatment, review PDR data each day.

Program supervisors have small caseloads (10 youth and families). They are on call 24 hours a day, 7 days a week, to MTFC parents and biological parents/relatives. Program supervisors conduct two weekly meetings that shape the form and pacing of the intervention (which is individualized for each youth). In the weekly foster parent meeting 7 to 10 MTFC parents, who are working with youth with similar problems, meet in a group to review the PDR data, talk about gains, and refocus the youth's individualized daily behavior management plan that foster parents implement in the MTFC home. In weekly clinical supervision meetings, family and individual therapists present on case progress and problems, and the program supervisor provides direction and feedback. Again, the daily PDR data are used to evaluate and revise the case plan.

**Table 1**  
Sample Description and Risk Factors for Boys  
and Girls at Baseline<sup>a</sup>

	Boys (N = 79)	Girls (N = 61)	Significance
Age in years	14.4	15.1	**
Single-parent family at present (%)	57.0	71.2	ns
Adopted (%)	9.1	8.2	ns
Family income less than \$10,000 (%)	37.3	35.7	ns
Number of crimes committed (by self)	13.5	13.1	ns
Mom was convicted of crime (%)	21.6	46.7	**
Dad was convicted of crime (%)	31.3	63.2	**
At least one parent convicted of crime (%)	41.1	70.0	**
At least one sibling was institutionalized (%)	20.0	37.3	*
Experienced (documented) physical abuse (%)	5.7	65.6	**
Experienced sexual abuse (documented) (%)	6.8	72.1	**
Attempted suicide (%)	2.6	58.3	**
Characterized as heavy drug or alcohol user (%)	9.3	82.0	**
Pregnant at least once (%)	N/A	29.3	
Number of prior treatment placements	1.33	3.03	**
Adolescent's report of days in detention year prior to baseline	73	72	ns
Ran away at least once (%)	73.7	91.7	**

<sup>a</sup> Unless otherwise noted, data are from referral agent and/or parent.

\* $p < .05$ ; \*\* $p < .01$ .

### Populations of Youth and Families

Randomized trials have been completed with boys referred from juvenile justice (Chamberlain & Reid, 1998; Eddy & Chamberlain, 2000), children and adolescents leaving a state hospital setting (Chamberlain & Reid, 1991), and children in state-supported foster care (Chamberlain, Moreland, & Reid, 1992). In each of these studies, referrals for MTFC were made by community agencies (i.e., departments of juvenile justice, child welfare, and mental health) to our community services clinic (OSLC Community Programs). There was no attempt to "weed out" cases with complex or comorbid conditions. In fact, referral to MTFC was typically preceded by failures in other types of placement settings, such as group or residential care.

*Juvenile justice participants* have a history of multiple criminal offenses (means = 14 offenses for boys and 11 for girls) prior to referral and, as a result of their chronic

delinquent behavior, are mandated to out-of-home placement by the court. Table 1 shows some of the characteristics and risk factors of boys and girls referred to MTFC from juvenile justice. As can be seen there, girls tend to be slightly younger, come from more disorganized chaotic and abusive families, and have more mental health problems. Other gender differences and treatment implications are discussed in Leve and Chamberlain (in press).

*Children and adolescents with severe emotional and behavioral problems* have typically experienced multiple placement failures before being referred to MTFC (e.g., the average in a recent sample was 4.75 previous placements) and have been diagnosed with multiple *DSM-IV* Axis I disorders (described in detail in Smith, Stormshak, Chamberlain, & Whaley, 2001). We serve children and adolescents referred from state and county mental health systems who range in age from 3 to 19 years.

#### **Overview of Personnel Who Implement the Oregon MTFC Model**

One distinguishing characteristic of the Oregon MTFC model is the use of a treatment team where staff roles are clearly defined. There is little or no overlap in the responsibilities of team members. Within the team there are multiple layers of staff involvement with the youth, biological (or other aftercare) family, and foster family. The aim is to implement a coordinated intervention in all relevant settings that provides the youth with close supervision, consistent limit setting and follow through, and meaningful adult mentoring. At the same time, the youth's parents are prepared for his or her return home. Staffing teams are structured to deal with 10 cases. They include 10 MTFC families, one full-time program supervisor, a half-time individual therapist, a half-time family therapist, and hourly skill trainers. In addition, the following positions can be shared across teams: foster parent recruiter, foster parent trainer and daily Parent Daily Report (PDR) caller, consulting psychiatrist, program director, and administrative personnel. Key staff roles are described below.

*TFC parents* come from various walks of life. Most have raised (or are raising) their own kids and genuinely like children and teenagers. They are people who think that parenting and home life are important. Both one- and two-parent families have been successful as MTFC parents, as have retired and younger people. Key characteristics are the desire to make a difference, to work as a member of a coordinated treatment team, and a sense of humor. MTFC parents are paraprofessionals. We regularly "promote" successful MTFC parents to other staff roles (recruiting, PDR caller, foster parent trainer).

*Program supervisor* act as the key contact with MTFC parents, provide supervision and direction for therapists,

and are the liaison to all other key players in the community (e.g., juvenile court judge, parole/probation officers, teachers). Program supervisors have a maximum caseload of 10 and are supervised weekly by the program director. They provide ongoing consultation to MTFC parents in weekly group meetings and review the daily telephone data. Group meetings focus on development and review of each youth's daily program, providing feedback to MTFC parents on the youth's strengths and on areas needing improvement, getting feedback from MTFC parents on how the program can increase the effectiveness of the support it provides, and coordinating special services such as tutoring or psychiatric consultation. Goals of the group meetings are to support and motivate MTFC parents and to develop a professional team approach. The program supervisor provides consultation and on-call crisis intervention to MTFC parents on a 24-hour basis.

Program supervisor qualifications include being familiar with adolescent development and developmental psychopathology and training in social learning principles. Levels of formal education vary from bachelor's degree with extensive experience to Ph.D. in psychology or related fields. The program supervisor's tasks are complex in that they balance the agendas of all team members to provide youths and their families with integrated treatment plans. Key characteristics of successful program supervisors are that they are flexible thinkers and excellent problem solvers.

*Family therapist.* A key component to the success of the MTFC program is the degree to which youth can generalize from the gains they have made during treatment to their posttreatment environments. Parents (or other adult guardians) are the primary social agents that determine the quality and consistency of this generalization in aftercare. Our analyses show that to the extent that the youth experiences thorough supervision, reinforcement for appropriate/positive behaviors, consistent and fair discipline for rule violations and misbehavior, and is not allowed to have unsupervised time with delinquent peers, she or he will engage in less criminal behavior in follow-up. Although it is tempting to think that participation in the program fundamentally changes delinquent youth, without continued parental (or adult) support and socialization in follow-up, gains do not maintain. Therefore, teaching parents how to effectively supervise, discipline, and encourage their child is a major task undertaken during the placement.

Components of the parent management training model we use are adapted from those previously developed and tested with families of antisocial children and adolescents. A number of studies conducted by different investigators have shown that compared to individually oriented treatments, Parent Management Training (PMT) has positive effects on child and family outcomes (Patter-

son, Chamberlain, & Reid, 1982; Prinz & Miller, 1994; Webster-Stratton & Hammond, 1997). In the Oregon MTFC program we incorporate the basic components of PMT, including first establishing a consulting role with the youth's parents. Often families have had multiple experiences with service providers and may currently be working with a number of agencies in addition to our program. For many of these families, their experiences with social service agencies have ranged from neutral to poor and have involved blame, confrontation, avoidance, and other negative events. Thus, it is important for the therapist to develop an alliance with the family and establish a relationship that is supportive and constructive prior to introducing parent-training techniques.

The family therapist works with parents to plan and implement strategies to increase reinforcement for positive/appropriate youth behavior. The therapist works with parents to help them understand the necessity of providing their youngster with close supervision and develop methods for doing so that take into consideration logistical constraints the parent faces. Parents are instructed in procedures for following through on rule violations and misbehavior with fair and consistent discipline. Finally, the importance of the youth associating with nondelinquent peers is emphasized.

As with most PMT models, in-home practice of skills talked about in treatment sessions is emphasized. As the parent learns particular skills, supervised visits with the child at the treatment center are initiated. As multiple skills are learned, the visits lengthen and then are transitioned to the family's home. Parents have specific practice assignments that they implement during the youth's home visits. Not only do parents and youth have a chance to try new ways of relating through these assignments, but gradually the balance of power shifts and the youth is more accepting of parental guidance and support. Ultimately, home visits extend to overnights and then weekends. This process continues until reunification. The family therapist maintains contact with the family during this transition and following reunification. Family therapists are master's-level clinicians.

*Youth therapist.* Initially, the primary role of the therapist is to serve as an advocate for the youth as he or she adjusts to life in the foster home. This is necessary because many of the youth we serve have poor social skills and are unable to advocate effectively for themselves. For example, an adolescent who believes that the foster parents are being too strict about chores or homework completion might decide on his or her own to simply refuse to comply. The therapist would likely sympathize with the youth about it being difficult to lead such a structured life, but would move the youth to develop a plan for discussing the problem with the program supervisor. At the same time, the youth therapist would bring the youth's

concerns to the attention of the program supervisor. The program supervisor and the MTFC parent would then plan a response to the youth's concerns. Ideally, that response would reinforce the youth for using appropriate problem-solving skills.

The youth therapist also participates in therapy sessions with the biological family, again serving primarily as an advocate for the youth. This is helpful in getting parents and youths to role-play solutions to problem situations, especially in families where there has been a great deal of conflict and chaos. In some circumstances, youth may address issues of past maltreatment or abuse with their therapists. However, this typically does not occur until the youth has spent some time in the foster home and his or her behavior has stabilized.

*Behavior support specialist.* The behavioral support specialist (BSS) is a bridging individual—a young bachelor's-level adult whose job is to teach youth effective ways of "being" in the community. Much of the work of the BSS involves teaching the youth prosocial behavior and problem-solving skills through intensive one-on-one interaction, role-playing, and modeling. A BSS might take on simple tasks such as practicing skills for entering a store and asking for help. The BSS can be especially useful for youth where school has been a generally negative experience. BSSs can help youth learn appropriate classroom behavior and conflict-resolution skills. A BSS works with a youth for 1 to 6 hours per week.

BSSs are trained to use applied behavior analysis as a way of examining potential antecedents to and reinforcers for problem behavior in the youth's environment. They are also instructed in the use of shaping techniques to teach new behaviors. Implementation of their interventions often is based on behavioral contracting with the youth, such as a reward for a certain number of days without a particular problem (as reported by the foster parent).

*Foster parent trainer, recruiter, and PDR caller.* This person is a paraprofessional, who, ideally, has experience as a successful MTFC parent. He or she conducts daily telephone contact with MTFC parents, participates in the preservice training of MTFC parents, recruits new parents, attends weekly foster parent meetings, and provides backup coverage to the program supervisor.

#### **Rationale for the Division of Clinical Roles and Functions**

In many treatment program models staff members are assigned to generalist roles working across multiple domains that may include youth therapy, family therapy, and case management. In the Oregon MTFC programs we use a team approach where separate and stratified staff roles and functions are clearly defined and there is little overlap between roles. Having staff operate within

defined roles increases our ability to both support and discipline youth. For example, program supervisors are the primary rule definers and enforcers. MTFC parents can call on program supervisors when they want to create new rules or tighten up on supervision without placing added stress on their relationship with the youth. Therapists, on the other hand, act as the youth's advocate and do not set limits or participate in discipline. They help the youth figure out (socially acceptable) ways to cope with school and program requirements. The youth's parents have an ally in the family therapist. If parents want a home visit, the family therapist advocates for it. The program supervisor decides whether (or where) a given visit occurs depending on a number of factors (e.g., the parent's ability and willingness to supervise the youth's peer associations, the youth's compliance with the "on time" rules during the past week). In these ways program supervisors, youth and family therapists work together to maximize contingencies and supports for youth and their families. The stratification of these roles also helps to respond strategically to treatment resistance so that supportive relationships can be maintained by one team member while another confronts problems.

#### Overview of Outcomes

Results from three completed randomized trials will be briefly reviewed. More complete reports can be found in Chamberlain and Reid (1991) for the state hospital study, in Chamberlain, Moreland, and Reid (1992) for the study on the application of MTFC to "regular" state foster care, and in Chamberlain and Reid (1998) and Eddy and Chamberlain (2000) for studies on juvenile justice youth.

*State hospital study.* The effectiveness of MTFC was compared to "community treatment as usual" for children (ages 9 to 18) leaving the state mental hospital. Participants had been hospitalized for an average of 245 days during the year prior to referral. Children were referred by the hospital community outreach team as being ready for placement in the community. Measures included the Parent Daily Report (PDR) Checklist to examine rates of problem behaviors, the Behavior Symptom Inventory to examine the presence/absence of psychiatric symptoms, and tracking of rehospitalizations. Results showed that youngsters in the MTFC group were placed out of the hospital significantly more quickly and more often than those in the control condition. In fact, during the 7-month follow-up period, 33% of the control condition youngsters remained in the hospital the entire time due to no appropriate aftercare resource being identified. Next, given that the child was placed in the community, more MTFC youngsters were placed in family settings. Control youth tended to be placed in more restrictive institutional settings. Although there were no differences

found on rehospitalization rates for the children who made it out of the hospital during the study period, a greater proportion of the children referred to MTFC were placed in the community than those in the control group. Significant differences were found during follow-up on adult reports of the occurrence of child problem behaviors, with children in MTFC having fewer problems than controls.

*Application of MTFC to "regular" foster care.* The impact of conducting selected parts of the MTFC model on key child welfare relevant outcomes was tested in state foster care offices in three Oregon counties. Key outcomes examined were rates for placement disruption, foster parent retention, and child behavior problems. Seventy foster families were randomly assigned to one of three conditions: assessment only, payment only, or enhanced training and support (MTFC "Lite"). In the MTFC Lite condition, foster parents met weekly in groups with a trained (and supervised) facilitator who was an experienced foster parent. In addition, they received PDR calls each week. Foster parents were provided with support and were taught a set of skills aimed at increasing their ability to manage the day-to-day behavioral and emotional problems exhibited by their foster child(ren). Foster parents in the MTFC Lite condition were paid a monthly stipend (\$70) to cover expenses associated with participating in the study (e.g., transportation). In the payment-only group, foster parents did not participate in the enhanced services but did receive the monthly stipend. In the assessment-only group, the foster parents did not receive the extra services and they did not receive the monthly stipend.

The measures were: (a) using the PDR Checklist to assess rates of child behavior problems, (b) tracking child disruptions in placement, and (c) tracking rates of foster parents dropping out of the system (i.e., foster parent "burnout"). In terms of child outcomes, children whose foster parents participated in MTFC Lite had significantly fewer disruptions in their placements. Children in the MTFC Lite group also showed the largest drop in rate of problem behaviors at 3 months follow-up. In the MTFC Lite condition, fewer foster parents dropped out; that is, there was a significantly higher retention rate for foster parents in that condition. The results of this study were encouraging. The next step was to see if we could disseminate the MTFC Lite intervention in a larger, more ethnically diverse child welfare system. Such a study is currently under way in San Diego County. That study is described in greater detail below.

*Juvenile justice study.* Seventy-nine boys between the ages of 12 and 17 were referred by the juvenile justice system over a 4-year period. Prior to referral, study boys averaged 14 previous criminal referrals and 5 previous felonies. All 79 boys had been detained for some period of time prior to entering the study; the average number

of days spent in detention was 76. All of the boys had previously been placed out of their homes at least once. Seventy percent had one prior out-of-home placement, and 30% had at least two prior placements. The mean age at entry into the study was 14.9 years ( $SD = 1.3$ ), and the mean age at first arrest was 12.6 years ( $SD = 1.82$ ). Boys were randomly assigned to placement in MTFC or group care (GC).

In GC, boys went to 1 of 11 GC programs located throughout the state. GC programs had from 6 to 15 youths in residence. Although programs differed somewhat in terms of their theoretical orientations, variations of the positive peer culture approach (Vorrath & Brendtro, 1985) were most often used. Youths participated in individual and group therapy as part of their programs. They most often attended in-house schools (i.e., 83% of cases). Family contact was encouraged and family therapy was typically provided when families could commute to program sites (i.e., 55% of cases).

A central question was whether or not it would be feasible and safe to place such chronic and serious offenders in alternative nuclear families in the community. Fewer boys in MTFC than in GC ran away from their placements (30.5% vs. 57.8%, respectively;  $p = .02$ ). A greater proportion of MTFC boys than GC boys ultimately completed their programs (73% vs. 36%, respectively;  $p = .001$ ). During the year after referral, boys in MTFC spent significantly fewer days in lock-up than did GC boys ( $p = .001$ ). This included fewer days in local detention facilities (MTFC,  $M = 32$ ; GC,  $M = 70$ ) and fewer days in the state training schools ( $M = 21$  and 59 days, respectively). Overall, compared to GC boys, boys in MTFC spent 60% fewer days incarcerated during the year following referral.

The second question was whether or not MTFC would be effective, compared to GC, in reducing subsequent crime and delinquent activity. Arrest data for criminal activity documented in official juvenile court records for the period 1 year prior to enrollment through 1 year post-discharge or expulsion from treatment were analyzed. Delinquent and criminal activities self-reported by participants were also examined for the year after baseline. There were significant group-by-time interactions found for rates of official arrests and self-reported criminal offenses with MTFC boys showing larger decreases post-treatment than boys in GC.

*Program costs.* At the time of the juvenile justice study, the MTFC program was funded by the Oregon Youth Authority (OYA) at the rate of \$76 per boy per day, or \$2,356 per month. This funding level, with 3% yearly cost-of-living adjustments, had been in effect since 1983, when the program started. GC programs varied in their funding from \$120 to \$160 per day per youth, or from \$3,720 to \$4,960 per month. In a recent cost-benefit analysis conducted by the Washington State Institute for Public Policy (Aos,

Phipps, Barnoski, & Lieb, 1999), the Oregon MTFC model was calculated to save taxpayers \$43,661 per participant in criminal justice and avoided victim costs. For every dollar spent on MTFC, \$22.58 of taxpayer benefits were estimated. The funding rate for Juvenile Justice programs in 2001 is \$115 per youth per day.

#### Dissemination of MTFC

Publication of results from the first randomized trials initially led to inquiries from various agencies wanting to implement MTFC. In 1996, we were selected as one of 10 national Blueprint Programs by the Colorado Center for the Study and Prevention of Violence, the Centers for Disease Control, and the Office of Juvenile Justice and Delinquency Prevention (Elliott, 1998). More recently, the Oregon MTFC model was highlighted in two Surgeon General reports on children's mental health services and youth violence (U.S. Department of Health and Human Services, 2000a, 2000b). The Safe, Disciplined, and Drug Free Schools Committee from the U.S. Department of Education also named Oregon MTFC an exemplary program.

We began our dissemination efforts in the late 1980s and early 1990s by conducting periodic week-long seminars in Oregon on MTFC. Staff members have made numerous presentations about the model around the U.S. and in Mexico, Italy, and Sweden. The first agency to implement MTFC on a wide scale was Youth Villages in Tennessee. In the early 1990s we began training their staff and have continued to consult with them. Initially, a group of Youth Villages administrators and direct line staff were trained on the MTFC model at our center. Subsequently, we sent trainers to their site on numerous occasions. Youth Villages staff members continue weekly telephone consultation with one of our program supervisors about individual cases.

Currently, Youth Villages serves over 400 children and adolescents a day in MTFC (Mendel, 2001), making it the largest MTFC site that we know of to implement the Oregon MTFC model. Although, to our knowledge, Youth Villages has not conducted a formal outcome study, they report that they are able to serve many more youth in less restrictive placements than they did before using MTFC, and that youth are more successful at remaining at home postplacement than they had been before implementation of the Oregon MTFC model. In addition to getting better outcomes in MTFC placements than they had previously using residential care beds, Youth Villages reports that MTFC costs substantially less.

Another, more recent successful implementation of the Oregon MTFC model has been with the Laurel Hill Youth Services program in Williamsport, Pennsylvania. The program director, David Hall, and three staff members from Laurel Hill were trained at the Oregon site in

January 2001. They began implementation at their site soon afterward. By 6 months after the initial training, they had served nine youth, and an additional two had completed the program and were successfully returned home. The Laurel Hill program serves youth referred from juvenile justice who are in need of out-of-home placement. Mr. Hall reports that the program is working well at their site, particularly in dealing with difficult youth who would have been placed in more restrictive residential programs prior to their implementing MTFC. We continue to conduct weekly telephone consultations with Laurel Hill staff, view videotapes of their family therapy sessions, and review daily PDR data they collect on program youth.

An international application of MTFC is being conducted in Lund, Sweden. There, a private agency serves youth referred from child welfare who have severe emotional and behavioral problems. Training for that site has involved two week-long intensive workshops in Sweden and two visits from their staff to the Oregon site. Preliminary data on outcomes for children served in that program appear to be promising (Hansen, personal communication, August 2001).

*Overview of steps for implementation.* Implementation of MTFC in other sites involves a series of steps. We begin by conducting an Organizational Readiness interview with interested agencies. The aim is to assess the agency's history of service provision, their current resources and staffing patterns and levels, their relationships with key community stakeholders (e.g., juvenile justice, mental health), and potential barriers to implementation. Next, the site identifies a core team of staff members to be trained. The core team should minimally include an administrator, a program supervisor, a therapist, and a foster parent trainer/recruiter. The team attends a 3-day training in Oregon. They attend training sessions, MTFC parent meetings, and clinical staff meetings. We then send two trainers to the agency site to train their first cohort of MTFC parents, conduct additional staff training, and prepare them to use the PDR Web site. They are then ready to place youth. Once youth are placed, we review daily PDR data for all cases and conduct weekly telephone consultation with their program supervisor(s) and therapists. During the first year of implementation, we conduct telephone consultation and three additional training sessions (2 days each) at the site.

*Tracking of program fidelity and outcomes.* The PDR was originally developed as an outcome measure in the context of research studies on parent-child interaction patterns. The PDR checklist provides data on the parent's perception of the occurrence of specific child behaviors during the past 24 hours. It was originally used to augment home observations conducted by trained observers in family homes. PDR data are a compromise between

the types of micro-social data that can be obtained in observations and more global parent reports of child functioning. We now use PDR both as an outcome measure and as a tool to continuously track the level of program implementation and fidelity. Each day, parents are telephoned and asked about the occurrence or nonoccurrence of a list of problem behaviors that are tailored to the developmental level of the child.

Data on child behavioral adjustment are augmented by additional data on foster parent stress level and data on the implementation by the parents of a structured daily behavior management plan. The program supervisor reviews these data each day for each MTFC case. In weekly foster parent meetings, PDR data are used to track progress and to retune the youth's individualized daily behavior management plan. In weekly clinical meetings, the program supervisor uses PDR data as a tool for supervising individual and family therapists and skill trainers. Finally, PDR is used as an outcome measure along with data on restrictiveness of living situation and other relevant indicators (e.g., arrests, days hospitalized).

In 2001 we developed a Web-based version of PDR that allows MTFC sites to enter data into our PDR software program. Those data are used in weekly telephone consultation sessions with participating sites.

*Specific and general barriers to dissemination of MTFC.* Initial implementation of the Oregon MTFC model can be difficult because it requires that a number of aspects of the program be brought on-line in a planned and timely way. Without a clear plan for program development that includes a well-thought-out time line for implementation of key start-up functions, the program will flounder and may ultimately fail. Start-up requires a commitment of sufficient staff and administrative resources that are coordinated and complementary. Initially, specific challenges are:

- to recruit a pool of qualified foster parents;
- to have them certified in a timely way;
- to match referrals to homes;
- to orient foster parents and staff to a way of working that promotes cooperative teamwork.

More general challenges have to do with overcoming perceptions that youth with such severe and persistent problems can be effectively and safely dealt with in the context of a family setting. In looking at the types of programs that are now in place in the United States for such youth, many, if not most, of our current practices seem to have to do more with setting up things so they are convenient for programs and the adults who run them than for getting positive outcomes for youth and families. Notable exceptions are the family-oriented Multisystemic and Functional Family Therapy models that were described earlier. The notion that we can deal with youth with mul-

tiple and severe conduct problems in group settings with the rationale that somehow the group interaction will serve a therapeutic effect is both counterintuitive and not supported by any empirically based studies.

*Challenges in start-up.* It is common for beginning programs to have initial difficulty recruiting foster parents. When recruitment efforts begin to pay off, sometimes referrals to the program are no longer in place. MTFC parents without placements do not last long (i.e., if programs have delays in using MTFC homes, they lose them). Start-up involves not only being able to recruit and train qualified staff and MTFC parents, but doing it in a timely way that is coordinated with availability of referrals.

Certification of MTFC parents can be a barrier. Requirements vary widely from state to state. Program developers should thoroughly understand the certification requirements and processes in their area. It is helpful to have worked out a clear arrangement with the agencies responsible for certification and to know who from that agency will work with the new MTFC program. It should also be understood what roles the MTFC program and the agency will play in the certification process. We have found that in many settings it is common for certification agencies to expect that it will take several months for foster parents to pass the requirements. It may be seen as part of a test of the foster parents' level of commitment to have them go through a lengthy process. This is usually not workable, and we have found that it is not necessary for screening MTFC parents. It has been our experience that there is usually a way to expedite the process if the certification agency considers the certification of certain parents a priority (emergency or expedited certification is a common practice). Beginning MTFC programs need to have the certification process clearly understood and in place prior to recruiting foster parents.

Some sites have had experience with recruiting foster parents and have existing foster homes that they want to convert to MTFC homes. This can be a big advantage if the foster parents are willing to play a more active, treatment-oriented role and if the implementing agency is prepared to compensate them appropriately. What does not work is the agency deciding to convert to MTFC and informing foster parents that things are changing. Often foster homes that have functioned well in a more independent role are not willing to accept the close staff involvement that MTFC requires.

Program staff turnover is another major barrier to successful implementation of MTFC, especially at the program supervisor level. We have found that if the team is functioning well and has good leadership from the program supervisor, foster parent turnover is usually quite low.

*Creating the "right" culture in new programs.* When we began disseminating MTFC, we noticed that we were not ef-

fective at communicating about a number of basic, "big-picture" assumptions underlying our model. The first had to do with characteristics of the relationship between the program staff (and most specifically the program supervisor) and MTFC parents. When conducting trainings, we emphasized the importance of establishing a supportive and collaborative relationship with foster parents. Program developers and staff members would readily agree that this made sense. The idea that the foster parents would help shape the intervention agenda was also largely noncontroversial. However, as the new programs were implemented, it would often become clear that there were significant challenges involved in working out these relationships and roles. It was often difficult for new program staff to break out of the idea that the therapist's agenda should drive treatment. It was also sometimes difficult to operationalize these values in daily practice.

For example, after years of implementing the MTFC model at our home site, we have evolved a culture whereby all staff members are trained to operate in ways that reinforce the idea that the relationship between the MTFC parent and the youth is primary. Program staff members work to empower foster parents and give them the skills and supervision to make smart decisions about the use of daily contingencies in their interactions with youth. Program supervisors try to prevent anything from happening that undermines the foster parent's reinforcing role or relationship with the youth. This includes occasionally protecting foster parents from unpopular decisions that might have to be made (e.g., limiting a youth's contact with certain peers) by having the program supervisor deliver the bad news. This stratification of authority helps the foster parent stay in the role of youth advocate and puts the program supervisor squarely in the line of fire. Program supervisors need a good understanding of how and when to step in so they can structure daily operations and supervise other program staff and MTFC parents to reinforce the overall goals of the program. In terms of training to this issue, we have found that it is most effective for new program staff to see examples of how these dynamics work in our foster parent meetings and talk with existing MTFC parents at our site.

Another way of conducting the MTFC model that has important implications for daily practice is by placing strong emphasis on interventions that attend to specific aspects of daily behavior. To avoid being overly organized by reactions to antisocial behavior, we attempt to carefully attend, at a daily level, to what the youth is doing right. This requires that a consistent level of staff and MTFC parent time and attention be spent on noncrisis topics. The MTFC program culture is to intervene sooner rather than later and to try to direct the bulk of the attention to normative or positive behavior. We have put structures in place to help accomplish this goal (e.g., the daily

behavior management system that MTFC parents run in their homes), but find that it requires ongoing supervision of staff to maintain the focus.

### System-Level Barriers

Barriers to implementation at the system level can pose significant threats to successfully implementing MTFC. We have encountered the following common barriers:

- *A lack of commitment to designating a staffing team whose primary responsibility is to implement MTFC:* Having part-time staff with competing responsibilities undermines the quality of the MTFC program. Staff members tend to forgo daily contact with MTFC parents when they perceive that things are going well. The result is that small problems are not addressed therapeutically, teaching opportunities are missed, and crises develop. When larger issues emerge, part-time staff are often not able to respond in a timely way, the confidence of the MTFC parents erodes, and placements disrupt.
- *A lack of confidence on the part of referring agents (typically probation and/or parole officers) that severely delinquent youth can safely be placed in family homes or attend public school:* Probation/parole officers are usually quite familiar with the youth being referred and have seen him or her fail in multiple past situations (most of which have involved the youth having daily contact with delinquent peers). Because the youth has not responded well to repeated past interventions that have been part of their agreement with their supervising court officer, there is the belief that the youth is not amenable to the influence of adults. The idea of placing the youth in a family setting is seen as being ineffective and even potentially dangerous. It is common for youth who are referred for MTFC services to have failed repeatedly in public schools. The perception that these youngsters cannot "make it" in school is often given as a reason for not referring a youth to MTFC. However, with close supervision, and careful monitoring of attendance, behavior, and homework completion that is provided as part of the MTFC model, it is relatively rare that youths' failures in school compromise their success in the program.
- *Blended funding involving multiple agencies can create competing or confusing expectations about a number of issues.* Some of these relate to disagreements between participating agencies about which youth are placed first in the available slots, different expectations that various agencies have about the proper length of stay, decisions about whether the MTFC parents are qualified or have the "right" training for working with child welfare, mental health, or

juvenile-justice-referred youth. We have found that single-source funding allows the program to develop clearer and more straightforward procedures that are responsive to the expectations of the funding agency.

### Conclusion

The MTFC model is fairly complex, and a number of key functions and staff roles must be well coordinated for things to run well. Initially, this means establishing productive working relationships with referral and foster parent certification resources, deploying a well-trained program staff, and having the mechanisms set up to provide ongoing supervision to that staff. In implementing the MTFC model, we stress the importance of monitoring the daily interactions between foster parents and program youth so that sufficient focus can be placed on strengthening positive functioning and reactive responding so that problem behaviors can be minimized. To help accomplish this and to promote program integrity, daily data on youth and foster parent functioning are collected. These data are used to continuously monitor key program processes and outcomes. An MTFC team that accumulates experience working effectively together can deal with increasingly challenging youth over time. Once established, MTFC programs can be expanded and future program development can be tailored to serve a wide range of youth and families.

The MTFC model described in this article represents a departure from many typical mental health and child welfare practices. For example, paraprofessionals (the MTFC parents) provide the front-line services, therapy often takes a back seat to promoting youth skill development in typical age-appropriate activities, and group treatment for youth is avoided. These elements have been included in the model because they have been shown in research studies conducted at OSIC and elsewhere to have positive influences on outcomes. The continued development of such research-based practices is very much needed so we can gradually accumulate the knowledge to strengthen the program models that are available to children and families.

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## Lessons Learned From the Dissemination of Parenting Wisely, A Parent Training CD-ROM

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*An intervention was developed that did not rely upon trained or experienced service providers for its delivery to families with behavior-disordered children and youth. The format is an interactive CD-ROM geared toward low-income, single-parent families. The very brief intervention offers privacy and engagement, unlike traditional methods, and its low cost to implement has enabled it to be disseminated to over 300 agencies in 4 years. The supporting research showing moderate effect sizes on child problem behavior, both in university and community settings, is described. Dissemination efforts began with the formation of a company for marketing the program through a university business incubation center. Of the agencies using the program, 93 were surveyed as to factors associated with successful implementation. Administrative support, practitioner buy-in, and a commitment to evaluate the program added accountability for client outcomes, all of which accounted for 30% to 40% of the variance in implementation success. Steps to maintain effective programs are outlined.*

PARENTING WISELY (PW) is an interactive CD-ROM parent-training program that runs on an IBM-compatible computer. The program combines the powerful effects of teaching parenting skills via videotaped modeling (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988) with the responsiveness of a computer program (Bosco, 1986). Each user's responses determine the subsequent content and feedback that he or she receives, much like

an interaction with a therapist. The PW program presents the parent with nine different problem situations that are common in many families. These include getting a child to complete homework, getting children to do household chores, and dealing with stepparent/stepchild conflict. When a problem is selected, a short video plays in which actors illustrate the problem. After the initial problem situation is presented, a screen appears that prompts the parent to select the method he or she normally uses (from a list of three solutions) to respond to the child's problematic behavior. The parent then watches as his or her selected solution is played out in the video. After the video segment is completed, the computer provides the parent

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